

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012623 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/01/2012 |
| NAME OF PROVIDER OR SUPPLIER SAXONY SURGERY CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 13100 EAST 136TH STREET STE 1100 FISHERS, IN 46037 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| S 000 | <p>INITIAL COMMENTS</p> <p>This visit was for licensure preoccupancy survey.</p> <p>Date of Survey: 03-01-12</p> <p>Facility number: 012623</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Indiana University Health Saxony Ambulatory Surgery Center meets the requirements for 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules to admit and treat patients.</p> <p>QA: cloughlin 03/02/12</p> | S 000 | | | |

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

MOIZ11

If continuation sheet 1 of 1